TRANSITION OF CARE FORM

Benefit Options
Choice Value Health

Please note that this information pertains to you and/or your dependents health care and is not intended for authorization of services.
If you are currently under the care of a non-network provider, there are a limited number of medical conditions that may qualify for Transition of Care. If transitional care is appropriate, specific treatment by a non-network provider may be covered at the network level of benefits for a limited period of time. These services are subject to eligibility and coverage limitations at the time the medical care is administered.

This form must be submitted within 30 days of your new enrollment date.

☐ **Please check box if this is dependent information.**

Employee Name:	**DOB:**	**Employee ID#:**
Dependent Name:	**DOB:**	**EPO** ☐ Aetna ☐ BCBSAZ ☐ UHC ☐ Cigna **PPO** ☐ Aetna ☐ BCBSAZ ☐ UHC
Day Time Phone: ( )		
Address:		**Medicare Primary** ☐**Yes** ☐ **No**
Primary Care Physician:		**Phone: ( )**

Do you use any specialty injectable medication other than insulin? ☐**Yes** ☐**No**
If yes, please list:

Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.

☐ Elective Surgery *(Including transplant)*	Facility: Nature of Surgery:	Date:	Physician Name: Phone:
☐ Pregnancy	Due Date:		Physician Name: Phone:
☐ Radiation Oncology	Facility:	Date:	Physician Name: Phone:
☐ Chemotherapy	Facility:	Date:	Physician Name: Phone:
☐ Dialysis	Facility:	Date:	Physician Name: Phone:
☐ Outpatient Rehabilitation	Facility:	Date:	Physician Name: Phone:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Therapy

☐ Home Health Services Agency Name: *(Including skilled nursing)* Nature of Services:

☐ Durable Medical Equipment Vendor Name:

Please check all that apply:

☐ Catheter supplies ☐ CPAP ☐ Bed/Mattress ☐ Other:
☐ Ostomy supplies ☐ Oxygen ☐ Wheelchair ☐ Diabetic Supplies

Do you have any of the following diseases: ☐ Diabetes ☐ Asthma ☐ CHF

Do you have any health care concerns where you may need assistance from a case manager? ☐ **Yes** ☐ **No**
Please explain:

Are you currently receiving mental health services: ☐**Yes** ☐ **No** **If yes, please provide the following:**
Provider Name: Provider Phone: ( ) Date of Next Appt:

Are you currently receiving substance abuse services: ☐ **Yes** ☐ **No** **If yes, please provide the following:**
Provider Name: Provider Phone: ( ) Date of Next Appt:

Please fax this form to your designated claim carrier:

Blue Cross Blue Shield of Arizona Administered by AmeriBen Transition of Care American Health Holding F-510 7400 West Campus Blvd. New Albany, OH 43054 Fax: (305) 751-1029	UnitedHealthcare Attn: Transition of Care 1311 W. President George Bush Hwy Richardson, TX 75080 Fax: (800) 628-0654	Cigna Health Facilitation Care Center Attention: Transition of Care 3200 Park Lane Drive Pittsburgh, PA 15275 Fax: (412) 747-7087	Aetna Public & Labor Segment Transition of Care 4645 E Cotton Center Blvd Bldg 1 Phoenix, AZ 85040 Fax: (860) 902 - 8364